

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

NARRATIVE FOR THE AMOUNT, DURATION AND SCOPE OF SERVICES

upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined, procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover: procurement costs; all hospital costs from admission to discharge for the transplant procedure; total physician costs for all physicians providing services during the transplant hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee reimbursement does not include pre- and post-hospitalization for the transplant procedure or pre-transplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse actual charges. Reimbursement for approved transplant procedures that are performed out-of-state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in (12VAC30-50-540 through -570) Attachment 3.1 E.

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12 VAC 30-50-140.

5. Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere. (continued)

L. Breast reconstruction/prostheses following mastectomy and breast reduction.

1. If prior authorized, breast reconstruction surgery and prostheses may be covered following the medically necessary complete or partial removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorized, for all medically necessary indications. Such procedures shall be considered non-cosmetic.
2. Breast reconstruction or enhancements for cosmetic reasons shall not be covered. Cosmetic reasons shall be defined as those which are not medically indicated, or are intended solely to preserve, restore, confer, or enhance the aesthetic appearance of the breast.

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6. Medical care by other licensed practitioners within the scope of their practice as defined by State Law.

A. Podiatrists' Services.

1. Covered Podiatry services are defined as reasonable and necessary diagnostic, medical, or surgical treatment of disease, injury, or defects of the human foot. These services must be within the scope of the license of the podiatrists' profession and defined by State law.
2. The following services are not covered: preventive health care, including routine foot care; treatment of structural misalignment not requiring surgery; cutting or removal of corns, warts, or calluses; experimental procedures; acupuncture.
3. The Program may place appropriate limits on a service based on medical necessity and/or for utilization control.

B. Optometrists' Services.

1. Diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians, as allowed by the Code of Virginia and by regulations of the Boards of Medicine and Optometry, are covered for all recipients. Routine refractions are limited to once in 24 months except as may be authorized by the agency.

C. Chiropractors' Services.

1. Not provided.

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- D. Other practitioners' services: psychological services, psychotherapy. Limits and requirements for covered services are found under Psychiatric Services (see 12VAC30-50-140 D).
1. These limitations apply to psychotherapy sessions provided, within the scope of their license, by licensed clinical psychologists or licensed clinical social workers/ licensed professional counselors/ licensed clinical nurse specialists- psychiatric who are either independently enrolled or under the direct supervision of a licensed clinical psychologist. Psychiatric services are limited to an initial availability of 26 sessions, with one possible extension of 26 sessions during the first year of treatment. The availability is further restricted to no more than 26 sessions each succeeding year when approved by the Psychiatric Review Board. Psychiatric services are further restricted to no more than three sessions in any given seven-day period.
 2. Psychological testing is covered when provided, within the scope of their license, by licensed clinical psychologists or licensed clinical social workers/ licensed professional counselors/ licensed clinical nurse specialists- psychiatric who are either independently enrolled or under the direct supervision of a licensed clinical psychologist.

7. Home Health services.

- A. Service must be ordered or prescribed and directed or performed within the scope of a license of a practitioner of the healing arts. Home health services shall be provided in accordance with guidelines found in the Virginia Medicaid Home Health Manual.
- B. Nursing services provided by a home health agency.
1. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.
2. Patients may receive up to 32 visits by a licensed nurse annually. Limits are per recipient, regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient. If services beyond these limitations are determined by the physician to be required, then the provider shall request prior authorization from DMAS for additional services. Payment shall not be made for additional services unless authorized by DMAS.
- C. Home health aide services provided by a home health agency.
1. Home Health Aides must function under the supervision of a registered nurse.
2. Home Health Aides must meet the certification requirements specified in 42 CFR 484.36.

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3. For home health aide services, patients may receive up to 32 visits annually. Limits shall be per recipient, regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient.
- D. Medical supplies, equipment, and appliances suitable for use in the home.
 1. General requirements and conditions.
 - a. All medically necessary medical supplies and equipment shall be covered. Unusual amounts, types, and duration of usage must be authorized by DMAS in accordance with published policies and procedures. When determined to be cost-effective by DMAS, payment may be made for rental of the equipment in lieu of purchase.
 - b. DME providers shall adhere to all applicable DMAS' policies, laws, and regulations for durable medical equipment and supplies. DME providers shall also comply with all other applicable Virginia laws and regulations requiring licensing, registration, or permitting. Failure to comply with such laws and regulations shall result in denial of coverage for durable medical equipment or supplies which are regulated by such licensing agency or agencies.
 - c. DME and supplies must be furnished pursuant to a Certificate of Medical Necessity (CMN) (DMAS-352).
 - d. A CMN shall contain a physician's diagnosis of a recipient's medical condition and an order for the durable medical equipment and supplies that are medically necessary to treat the diagnosed condition and the recipient functional limitation. The order for DME or supplies must be justified in the written documentation either on the CMN or attached thereto. The CMN shall be valid for a maximum period of six months for Medicaid recipients 21 years of age and younger. The maximum valid time period for Medicaid recipients older than 21 years of age is 12 months. The validity of the CMN shall terminate when the recipient's medical need for the prescribed DME or supplies ends.
 - e. DME must be furnished exactly as ordered by the attending physician on the CMN. The CMN and any supporting verifiable documentation must be complete (signed and dated by the physician) and in the provider's possession within 60 days from the time the ordered DME and supplies are initially furnished by the DME provider. Each component of the DME must be specifically ordered on the CMN by the physician. For example, the order must specify IV pole, pump, and tubing. A general order for IV supplies shall not be acceptable.
 - f. The CMN shall not be changed, altered, or amended after the attending physician has signed it. If changes are necessary, as indicated by the recipient's condition, in the ordered DME or supplies, the DME provider must obtain a new CMN. New CMNs must be signed and dated by the attending physician within 60 days from the time the ordered supplies are furnished by the DME provider.

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- g. DMAS shall have the authority to determine a different (from those specified above) length of time a CMN may be valid based on medical documentation submitted on the CMN. The CMN may be completed by the DME provider or other health care professionals, but it must be signed and dated by the attending physician. Supporting documentation may be attached to the CMN but the attending physician's entire order must be on the CMN.
- h. The DME provider shall retain a copy of the CMN and all supporting verifiable documentation on file for DMAS' post payment audit review purposes. DME providers shall not create nor revise CMNs or supporting documentation for this service after the initiation of the post payment review audit process. Attending physicians shall not complete, nor sign and date CMNs once the post payment audit review has begun.
2. Preauthorization is required for incontinence supplies provided in quantities greater than two cases per month.
3. Supplies, equipment, or appliances that are not covered include, but are not limited to, the following:
- a. Space conditioning equipment, such as room humidifiers, air cleaners, and air conditioners;
- b. Durable medical equipment and supplies for any hospital or nursing facility resident, except ventilators and associated supplies for nursing facility residents that have been approved by DMAS central office;
- c. Furniture or appliances not defined as medical equipment (such as blenders, bedside tables, mattresses other than for a hospital bed, pillows, blankets or other bedding, special reading lamps, chairs with special lift seats, hand-held shower devices, exercise bicycles, and bathroom scales);
- d. Items that are only for the recipient's comfort and convenience or for the convenience of those caring for the recipient (e.g., a hospital bed or mattress because the recipient does not have a decent bed; wheelchair trays used as a desk surface;) mobility items used in addition to primary assistive mobility aide for caregiver's or recipient's convenience (i.e., electric wheelchair plus a manual chair); cleansing wipes;
- e. Prosthesis, except for artificial arms, legs, and their supportive devices which must be preauthorized by the DMAS central office (Effective July 1, 1989);
- f. Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (for example, dentifrices; toilet articles; shampoos which do not require a physician's prescription; dental adhesives; electric toothbrushes; cosmetic items, soaps, and lotions which do not require a physician's prescription; sugar and salt substitutes; and support stockings;
- g. Orthotics, including braces, splints, and supports;

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- h. Home or vehicle modifications;
 - i. Items not suitable for or not used primarily in the home setting (i.e., car seats, equipment to be used while at school, etc.);
 - j. Equipment that the primary function is vocationally or educationally related (i.e., computers, environmental control devices, speech devices, etc.);
- 4. For coverage of blood glucose meters for pregnant women, refer to Supplement 3 to Attachment 3.1 A & B.
 - 5. Reserved.
 - 6. The medical equipment and supply vendor must provide the equipment and supplies as prescribed by the physician on the certificate of medical necessity. Orders shall not be changed unless the vendor obtains a new certificate of medical necessity prior to ordering or providing the equipment or supplies to the patient.
 - 7. Medicaid shall not provide reimbursement to the medical equipment and supply vendor for services provided prior to the date prescribed by the physician or prior to the date of the delivery or when services are not provided in accordance with published policies and procedures. If reimbursement is denied for one of these reasons, the medical equipment and supply vendor may not bill the Medicaid recipient for the service that was provided.
 - 8. The following criteria must be satisfied through the submission of adequate and verifiable documentation satisfactory to the Department. Medically necessary DME and supplies shall be:
 - a. ordered by the physician on the CMN;
 - b. a reasonable and necessary part of the recipient's treatment plan;
 - c. consistent with the recipient's diagnosis and medical condition particularly the functional limitations and symptoms exhibited by the recipient;
 - d. not furnished solely for the convenience, safety, or restraint of the recipient, the family, attending physician, or other practitioner or supplier;
 - e. consistent with generally accepted professional medical standards (i.e., not experimental or investigational); and
 - f. furnished at a safe, effective, and cost effective level suitable for use in the recipient's home environment.
 - 9. Coverage of enteral nutrition (EN) which does not include a legend drug shall be limited to when the nutritional supplement is the sole source form of nutrition, is administered orally or through a nasogastric or gastrostomy tube, and is necessary to treat a medical condition. Coverage of EN shall not include the provision of routine infant formulae. A nutritional assessment shall be required for all recipients receiving nutritional supplements.

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- F. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.
1. Service covered only as part of a physician's plan of care.
 2. Patients may receive up to 24 visits for each rehabilitative therapy service ordered annually without authorization. Limits shall apply per recipient regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient. If services beyond these limitations are determined by the physician to be required, then the provider shall request prior authorization from DMAS for additional services.

Supplement 1 to
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F. The following services are not covered under the home health services program:

1. Medical social services;
2. Services or items which would not be paid for if provided to an inpatient of a hospital, such as private-duty nursing services, or items of comfort which have no medical necessity, such as television;
3. Community food service delivery arrangements;
4. Domestic or housekeeping services which are unrelated to patient care and which materially increase the time spent on a visit;
5. Custodial care which is patient care that primarily requires protective services rather than definitive medical and skilled nursing care; and
6. Services related to cosmetic surgery.

8. Private duty nursing services.

A. Not provided.

✓ 9. Clinic services.

A. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment of health or life to the mother if the fetus were carried to term.

B. Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that:

1. are provided to outpatients:

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